USAID/CAR
REPRODUCTIVE HEALTH STRATEGY
FOR UZBEKISTAN

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ACRONYM LIST

AIHA	American International Health Alliance
AVSC	Association for Voluntary Safe Contraception
CA	Cooperating Agencies
CAR	Central Asian Republics
CARAK	Central Asia Countries, Azerbaijan, and Kazakhstan Project
CBD	community-based development
DHS	Demographic and Health Survey
DPT	diphtheria and tetanus toxoids
FAP	feldsher station or doctor's assistant/midwife post
FP	family planning
GNP	gross national product
GOU	Government of Uzbekistan
GP	general practitioner
GTZ	German Development Agency
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
IEC	information, communication, and education programs
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PCS	Johns Hopkins University Population Communication Services
KAP	knowledge, attitude, and practice
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	nongovernmental organization
Ob-Gyn	obstetrics/gynecology
POPTECH	Population Technical Assistance Project
PPFA	Planned Parenthood Federation of America
PRB	Population Resource Bureau
RH	reproductive health care
RHSEP	Reproductive Health Services Expansion Program
SDP	service delivery point
SOMARC	Social Marketing for Change
STD	sexually transmitted disease
SVA	rural ambulatories
SVP	Rural Physician Post
TASHMI II	Second Tashkent State Medical Institute
TFR	total fertility rate
UN	universal nurse
UNDP	United Nations Development Programme

UNESCO	United Nations Education, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

Located in the center of Central Asia, Uzbekistan shares borders with Kazakhstan, Krygyzstan, Turkmenistan, Tajikistan, and Afghanistan. With a population of 23.7 million, it is the third most populous country of the former Soviet Union after Russia and Ukraine.

Uzbekistan is the world's third-largest cotton producer as well as a major producer of gold and natural gas. The production of chemicals and machinery for the Central Asian Region provides the nation with additional revenue. Uzbekistan also has other considerable mineral resources. After independence in 1991, the government of Uzbekistan (GOU) initially tried to maintain subsidies and to control prices and production, but the cost became increasingly unsustainable as inflation escalated and the economic situation worsened. The GNP in 1994 was estimated at $950, less than half that of Eastern Europe and other Central Asian countries. The government is now moving toward reform and is cooperating with the IMF and the World Bank. The GOU has accelerated the privatization process and has stepped up efforts to attract foreign investors.

Uzbekistan is densely populated in areas with cultivated river valleys; more than 60 percent of the population resides in such areas. Other areas in the west of the country are arid and sparsely populated. The Fergana Valley in the east is one of the most densely populated regions in the world and is home to one-third of Uzbekistan's population.

About 71 percent of the population is Uzbek, 8 percent Russian, and the remaining minorities Tajik, Karakh, Tatar, and Karakalpak, with each representing less than 5 percent of the total population. Islam is the predominant religion. Uzbek is the official language, although Russian is widely used in business and government. In 1993, the GOU decreed that Uzbekistan would adapt a Latin script. Literacy is almost universal for both males (98 percent) and females (96 percent), and the educational level is high, with median years of school for females at 10.1.

The total fertility rate (TFR) is 3.3 births per woman. Differences by rural and urban populations yield a TFR of 3.7 births per woman in rural areas and 2.7 in urban areas. The TFR for women in Tashkent is only 2.3. The population growth rate is 2.1 percent per year, with a 33-year doubling time. Uzbekistan's under-15 cohort accounts for 41 percent of the total population while only 5 percent of citizens are over 65 years of age.

According to the Uzbekistan Demographic and Health Survey (1996), 56 percent of married women reported using a contraceptive method; of these, 46 percent used the IUD. Contraceptive use appears to increase with parity such that 63 percent of women with two or more children reported using a method, mostly the IUD. Over 90 percent of Uzbek women surveyed know of at least one contraceptive method. Despite the availability of orals and injectables, the continued preference for the IUD probably reflects a provider bias based on poor experience with the high-estrogen orals supplied during the Soviet era and the fact that the physician still controls decision making in family planning clinics. Contraceptive technology updates and counseling training provided by two USAID Cooperating Agencies (AVSC and JHPIEGO) are addressing the physician bias toward IUDs. The SOMARC project is also dealing with physician bias by developing mass media messages that promote the safety of hormonals and ensuring wider availability of such products through commercial outlets.

Abortion rates have decreased by almost half since 1990, from 40.3 per 1,000 women to 20.7 in 1995. The MOH believes that the decrease is related to the wider availability of family planning services. Nonetheless, rates remain higher in urban areas, particularly in Tashkent. Among women who have had an abortion, 88 percent reported using no contraception while 12 percent reported experiencing contraceptive failure.

The GOU is negotiating with the World Bank to develop a health reform project in three oblasts (regions), including the Fergana Valley. Based on the Soviet model, the current health care system depends on an extensive infrastructure and centralized management. It is oriented toward curative care and is financially unsustainable. The World Bank Health Reform Project, however, will rationalize services, facilities, and personnel and institute management and financing systems. It will emphasize the provision of primary care and preventive services. The World Bank is expected to launch its reform project in the summer of 1998 by, first, refurbishing and equipping primary health care sites and, second, strengthening administration and financial management. USAID, through Abt Associates, is providing technical assistance to the GOU in the design and implementation of the project.

Based on previous and ongoing activities in Uzbekistan, USAID has provided effective reproductive health training for all levels of personnel, developed information programs for clients to increase the use of contraceptives, and promoted advocacy for improved RH services and support to the contraceptive social marketing project. The team recommends that USAID expand its support to include assistance to the World Bank as a means of addressing reproductive health issues in primary health care.

The team recommends that USAID/CAR field an RH assessment team for travel to the Fergana Valley in October 1998 to identify areas for interventions in reproductive health in the World Bank/Abt Project and to develop an implementation plan. A buy-in to the Partnerships for Health Project will provide a funding mechanism for the RH assessment.

The team noted that Uzbekistan lacks the legal and regulatory framework needed for instituting health reform activities and building the capacity of the private sector to deliver health care services. In particular, the GOU Ministry of Health generally sets policy through decree, with each decree dealing with one issue or event, such as a major policy change or the announcement of MOH support of a conference on a stated subject. The development of a framework for RH that includes information from all previous decrees and other sources related to RH delivery could provide a reasonable reference for developing service delivery guidelines for health care personnel. Such a framework is especially important as physicians and other health care personnel begin to assume different roles under health care reform. The team recommends that technical assistance in policy development be provided through funding to the POLICY Project to cover one-third of the time of the POLICY Project adviser resident in Turkmenistan.

One of the more successful RH initiatives in Uzbekistan has been the SOMARC Red Apple Contraceptive Marketing Program, which is now expanding beyond pharmacy sales and into the community by training peer counselors, setting up an information hot line, establishing community information rooms, and developing media materials. These activities are providing information to women, developing youth programs, and increasing sales of contraceptives through commercial

outlets. The activities will need continued support through additional funding to SOMARC to ensure sufficient funding for the development and distribution of media materials.

An NGO community that addresses the legal, social, and health needs of women is developing throughout Uzbekistan. At least one NGO has expressed interest in affiliating with the Planned Parenthood Federation of America. The team recommends funding an NGO partnership with a U.S.-based Planned Parenthood Federation of America affiliate.

RECOMMENDATIONS

Recommendation No. 1. USAID should conduct an assessment in early October 1998 to identify areas for USAID intervention in reproductive health in the World Bank/Abt pilot project. Based on the assessment, USAID should provide field support to the Global Bureau for the Partnerships for Health Reform project for technical assistance provided by Abt Associates to implement the activities suggested by the assessment team.

Recommendation No. 2. USAID/CAR should provide field support to the Global Bureau for the POLICY project to fund a policy adviser for both Turkmenistan and Uzbekistan. The adviser would be stationed in Turkmenistan and spend one-third of her or his time in Uzbekistan.

Recommendation No. 3. USAID should provide field support to the Global Bureau for the follow-on SOMARC project to support the contraceptive social marketing efforts in Uzbekistan for the next two to three years.

Recommendation No. 4. USAID/CAR should support the new Health Partnerships project to promote a partnership between a U.S.-based affiliate of the Planned Parenthood Federation of America and a women's NGO in Uzbekistan.

REPRODUCTIVE HEALTH ASSESSMENT FOR UZBEKISTAN

I. SECTOR OVERVIEW

A. Background

Located in the center of Central Asia, Uzbekistan shares borders with Kazakhstan, Krygyzstan, Turkmenistan, Tajikistan, and Afghanistan. It is densely populated in areas with cultivated river valleys; in fact, more than 60 percent of the population resides in such regions. The Fergana Valley in the east is one of the most densely populated regions in the world.

Uzbekistan is the world's third-largest cotton producer as well as a major producer of gold and natural gas. The production of chemicals and machinery for the Central Asian Region provides the nation with additional revenue. The country also has other considerable mineral resources.

Uzbekistan is undergoing a slow and difficult transition to a market economy. After independence in 1991, the government of Uzbekistan (GOU) initially tried to maintain subsidies and to control prices and production, but the cost became increasingly unsustainable as inflation escalated and the economic situation worsened. The GNP in 1994 was estimated at $950, less than half that of Eastern Europe and other Central Asian countries. The government is now moving toward reform and is cooperating with the IMF and the World Bank. In addition, the GOU has accelerated the privatization process and has stepped up efforts to attract foreign investors.

The GOU is negotiating with the World Bank to develop a health reform project in three oblasts; one of the oblasts is the Fergana Valley, which is home to one-third of the country's population. In the meantime, the current health system is based on the Soviet model and depends on an extensive infrastructure and centralized management. It is oriented toward curative care and remains financially unsustainable. The Health Reform Project will rationalize services, facilities, and personnel and put in place management and financing systems. It will also emphasize the provision of primary care and preventive services. USAID is providing technical assistance in health care reform to the World Bank in the design and implementation of the project and will explore further involvement in improvement of service delivery in reproductive health.

B. Status of Population Parameters and Reproductive Health

The primary sources of information on population parameters and reproductive health are the Uzbekistan Demographic and Health Survey (1996) and statistics provided by the Institute of Obstetrics and Gynecology, State Department of Statistics of the Republic of Uzbekistan.

With a population of 23.7 million in 1997, Uzbekistan is the third most populous country of the former Soviet Union after Russian and Ukraine. About 62 percent of the population lives in rural areas. About 71 percent of the population is Uzbek and 8 percent is Russian, with the remaining ethnic minorities (Tajik, Karakh, Tatar, Karakalpak, etc.) each representing 5 percent or less. The

population growth rate is 2.1 percent (PRB, 1997), which translates into a 33-year doubling if the rate of growth remains constant. The fertility level is 3.3 births per woman (TFR). The rate of population growth coupled with moderately high fertility has produced a young population. About 41 percent of citizens are under the age of 15 and fewer than 5 percent are 65 years of age or older.

Literacy is almost universal (98 percent for males and 96 percent for females), and the level of education in Uzbekistan is high. The median years of school for the female population is about 10.1. The educational system is organized into three levels: primary grades 1–4 (ages 6–7 to 10–11), principal grades 5–9 (ages 11–15); and secondary grades 10–11 (ages 16–17). Virtually all women have had some education, and a high percentage has gone on to secondary school or has received higher education, especially women ages 20–49 (DHS, 1996, Table 2.5). School enrollment is also high, with 83 percent of children age 7–17 enrolled in school and little difference by residence and sex.

B.1. Fertility and Marriage

For many years, the GOU promoted policies to encourage women to have more children. Women who in the past had seven or more children were traditionally glorified and recognized as "mother-heroes." They received several benefits, including bonuses, housing assistance, long-term paid maternity leave, child benefits, support for day care, etc. The MOH has revised its pronatalist policy and now promotes family planning services as a means of improving reproductive health.

In the first years after independence, Islamic leaders raised objections to family planning. Their opposition, however, was based on a misunderstanding of the Koran. The religious head of Al Ahzar University in Egypt, the premier Islamic university in the world, and the chief Egyptian Ob-Gyn came to Uzbekistan and explained that the Koran does not oppose family planning; to the contrary, it supports family planning.

While the national TFR for Uzbekistan is 3.3, there is some variation by residence, education, and ethnicity. In addition, there is a difference of one child between women living in urban versus rural areas. The TFR for rural areas is 3.7 compared with 2.7 for urban areas while the TFR for the capital Tashkent is even lower at 2.3. Women with higher education have fewer than three children on average (TFR of 2.8) compared with 3.5 children for women with primary or secondary education. Uzbeks have about one more child on average than do other ethnic groups (TFR of 3.5 compared with 2.5).

Fertility has declined in Uzbekistan in recent years. Completed family size among women age 45–49 is 4.6, which is more than one child greater than the current level of fertility. Levels of wanted fertility (the level of fertility that would have prevailed if all unwanted births had been prevented in the three years before the DHS survey as compared with actual levels of fertility) suggest that most women are bearing the desired number of children.

The ideal number of children is frequently used to assess fertility preferences. For women, the ideal number of children is 3.6, which is slightly higher than the TFR. Among younger women age 15–24, however, the ideal is closer to three children (3.3) and ranges from 3.5 to 4.4 among older women. In addition, women with fewer than three children state three as their ideal number of children in comparison with women with three or more children whose ideal ranges from 3.6 to 5.7. These differences add further support to declining fertility trends.

Information on patterns of child-bearing shows that the median age of child-bearing is 21.5 years. Urban women bear children about one year later than rural women (median age 22.2 years compared with 21.2 years for rural women). About one-quarter of women have their first child before age 20 (primarily at ages 18–19). While the peak age for child-bearing among women in both urban and rural areas is 20–24, child-bearing in Uzbekistan is generally concentrated among women age 20–29. The median birth interval is 2.5 years (fewer than 24 months is considered a short birth interval); however, about 41 percent of births to women in their 20s occur within 24 months of a previous birth. Health professionals in Uzbekistan are concerned that the short birth intervals are adversely affecting the health of mothers and children.

For several decades, the median age of marriage has been fairly constant at 20. Survey data on initiation of sexual activity and age at marriage suggest that sexual initiation is simultaneous with marriage. Anecdotal evidence suggests that a resurgence of traditional, Islamic influences is beginning to reduce the level of schooling for girls, thus promoting earlier marriage and earlier child-bearing.

B.2. Maternal Mortality and Abortion

Trends in maternal mortality in Uzbekistan since independence show a consistent decline from 478 deaths in 1991 to 219 in 1995 and down further to 132 deaths in 1996. Maternal mortality rates per 100,000 live births were 65.3 in 1991 and 32.2 in 1995 (Table 5, State Department of Statistics, Republic of Uzbekistan) (UNICEF's *The State of the World's Children 1998* gives a maternal mortality rate of 55 in 1990). About three-quarters of maternal deaths for the years 1993–1996 occurred among women living in rural areas, with more than half of the deaths attributable to women under age 30. The major causes of maternal death were obstetrical bleeding and toxemia, accounting for 30 and 19 percent of all maternal deaths, respectively. Most of the women who died had adverse health conditions unrelated to pregnancy (referred to as extragenital diseases) such as anemia and kidney diseases. These extragenital problems are listed as the primary cause of death for 15 percent of all maternal deaths. The Institute of Obstetrics and Gynecology indicates that the vast majority (86 percent) of maternal deaths could have been prevented (AVSC, 1996, p. 11). Recent trends show an increase in the number of C-sections reportedly for the purpose of reducing perinatal mortality. While only 3 to 5 percent of all deliveries are C-sections, nearly 45 percent of all maternal deaths occurred among women who had C-sections. C-sections appear to be strongly implicated in maternal mortality.

According to GOU statistics, the number of abortions in Uzbekistan has declined steadily from 192,500 in 1990 to 103,969 in 1995, with a concomitant decline in the abortion rate from 40.3 to 20.7 per 1,000 women age 15–49. This decline is directly attributable to the government's program to improve the health status of women by promoting the use of contraception. The 1996 Uzbekistan DHS also shows a decline in the abortion rate in recent years, although not as great as the decline shown in the government statistics. The difference is probably due to underreporting in the DHS survey.

Additional information on abortion in Uzbekistan shows that about 60 percent of all abortions were induced legal, mini-abortions (before three to four weeks of pregnancy) or induced by medical indication; an additional 40 percent were spontaneous. Most abortions (87 percent) are performed in hospitals, and most are performed by physicians. Data from the DHS show that a woman has on average less than one abortion (0.7) during her lifetime. The total abortion rate is much higher for women living in the capital city of Tashkent (1.3 abortions) than for women in rural areas (0.5). About 16 percent of all women in Uzbekistan have ever had an abortion, and about half of these women have had more than one abortion. Among women who have had an abortion, 88 percent did not use contraception at the time of the abortion while the remaining 12 percent apparently experienced a contraceptive failure.

B.3. Contraception

The status of knowledge of contraceptive methods is mixed. Of all women, 89 percent knew of at least one method, and 96 percent of married women had such knowledge. However, knowledge of particular methods varied greatly: 87 percent of all women knew of the IUD, but only 22 percent of all women knew of sterilization (27 percent of married women knew of sterilization). Knowledge of other methods such as diaphragm, foam, jelly, condom, and injectables ranged from 16 to 56 percent.

In 1996, contraceptive use was 56 percent among married women, with modern methods dominating. The IUD was by far the most common method (46 percent of married women); only 4 percent of married women used traditional methods of contraception such as withdrawal or periodic abstinence. The level of contraceptive use increased with increasing parity such that 63 percent of married women with two or more children used contraception (again, mostly the IUD) compared with only 6 percent of married women with no children and 35 percent of married women with only one child. Use of family planning to delay a first birth is uncommon in Uzbekistan. In fact, evidence suggests that younger women (aged 20–24) started contraceptive use after they had only two children while older women (over age 35) started contraceptive use after they had four children. Thus, women are using contraception earlier in their reproductive lives to delay and perhaps even to limit the number of births. This trend may bode well for the government's stated goal of promoting family planning as a means of reducing adverse health outcomes that result from inadequately spaced births.

Various groups of women in Uzbekistan may have an unmet need for family planning. As narrowly defined, women who want to space their children or stop child-bearing but do not currently use

contraception are considered to have an unmet need. Fourteen percent of women in Uzbekistan have such a need: half for spacing (spacers) and half for limiting births (limiters). An additional group of women who may or may not be captured among the spacers and limiters underwent an abortion and either were not using contraception or experienced a contraceptive failure. These women need contraception outright or must either correctly use a more effective method or switch to a different method. Further, given the heavy dependence on the IUD, it is likely that some women would prefer a different method (such as sterilization or injectables) if only they had knowledge of another method and such method were more widely available. Wide use of the IUD in Uzbekistan may involve an additional complication because of existing high levels of anemia. It is possible that some IUD users would be better off using a different method such as a hormonal method that typically involves a smaller blood loss during menstruation.

A note is in order on breast-feeding as a way to promote longer birth intervals. Breast-feeding is nearly universal among women in Uzbekistan, although exclusive breast-feeding is rare since supplementation begins early. Thus, for most women, breast-feeding does not provide reliable contraceptive effects through prolonged postpartum amenorrhea. Interesting data from the DHS show that most women (81 percent) believed that breast-feeding does not affect the risk of pregnancy. Given current patterns of breast-feeding, it is fortunate that women have such a belief.

Given the public sector's predominance in the delivery of health care services, it is not surprising that the vast majority of women obtained modern contraception from the public medical sector. Rural women were more likely than urban women to know of only one source of contraception; in contrast, 63 percent of women living in Tashkent knew of more than one source.

Both the predominant role of the public sector and the lack of alternative sources for contraception limit access to family planning. Based on the DHS, most nonusers of contraception (66 percent) did not visit a health facility in the year before the survey while another 21 percent did visit a facility but received no information or advice about contraception. The statistics point to a significant lost opportunity on the part of the health community to impart knowledge about family planning to the population (DHS, 1996, p. 59).

B.4. Sexually Transmitted Diseases

There is little reliable information on the prevalence of sexually transmitted diseases in Uzbekistan, and screening for STDs does not cover all types of infections (AVSC, 1996). The Institute of Obstetrics and Gynecology reports a steady increase in STDs but acknowledges that its numbers probably underestimate the current prevalence, especially given variations in the screening and diagnosis of different STDs. The MOH collects information on syphilis, gonorrhea, trichomoniasis, and candiasis, although it admittedly lacks an understanding of the importance of tracing sexual contacts and treating both partners.

B.5. Adolescent Reproductive Health

Gender equality is one of the legacies of the Soviet Union. However, today's social and economic hardships and the restructuring of the government may, when combined with a resurgence of more traditional ways, adversely affect the lives of adolescent girls. Increasingly, accounts indicate that young women and girls are leaving school, getting married, and having children earlier than in years past (UNICEF, February 1997). Data on school dropouts also suggest that girls are leaving school earlier to help support their families.

The DHS provides a few insights into the current status of adolescent reproductive health. Trends over a 20-year period for age-specific fertility show that adolescents age 15–19 demonstrated a slight increase in fertility in just the 1992–1996 period, from 53 to 56 births per 1,000 adolescents. However, early child-bearing is not particularly prevalent in Uzbekistan. Only 10 percent of adolescents age 15–19 had begun child-bearing at the time of the DHS, although nearly one-third (31 percent) of adolescents age 19 had either given birth or were pregnant with their first child. The vast majority of young women knew of a method of modern contraception (86 percent), although only 2 percent used any method. Induced abortion among this population is very rare. There are no available data on trends in premarital sexual activity, although the DHS data on initiation of sexual activity and age at marriage suggest little premarital sexual activity. Furthermore, the DHS indicates that virtually no unmarried women age 15–19 had a sexual partner. Nonetheless, some anecdotal evidence indicates that the situation may be changing.

C. Current Health and Reproductive Health Programs

C.1. Government of Uzbekistan

The health care system in Uzbekistan was developed as part of the Soviet-planned system and was intended to provide all citizens with adequate access to health care services. While the system has an extensive infrastructure, it is centrally managed, curative-based, and financially unsustainable. Facilities are poorly maintained and lack basic equipment and supplies. Even though consultations are supposedly free, anecdotal information reveals that health providers request informal payments for services. With the decline in state funding, more of the financial burden for obtaining necessary medicines has shifted to patients, many of whom, because of disruptions in the republic's economy, are themselves poorer than under the Soviet system.

Primary health care is provided in such institutions as polyclinics, outpatient clinics (ambulatories or SVAs), doctor's assistant/midwife posts (FAPs), primary health facilities at large enterprises, women's consulting centers (which are a primary source of family planning services in urban areas), and delivery hospitals. The main focus of health services in these institutions is disease prevention (for example, immunization against infectious diseases) and antenatal care services, delivery assistance, and family planning services.

At the secondary level, health services are provided by specialized dispensaries, departments of polyclinics, and hospitals. Tertiary health services are provided within the departments of regional, municipal, and district general hospitals and by specialized hospitals and dispensaries and clinical research institutes.

The GOU intends to restructure the organization and delivery of health care services in rural areas and, in particular, to strengthen the provision of primary health care to the rural population. A key underlying objective of the government's reform is to shift both care and financial resources from specialty services and inpatient facilities to providers of primary care. The GOU's strategy consists of two integrated parts as follows:

- The existing network of health care providers will be substantially restructured and consolidated. By 2000, most feldsher stations (FAPs) and rural ambulatories (SVAs) will be closed. In nearly all cases, they will be replaced by equal or greater numbers of a new institution called a Rural Physician Post (SVP). The SVP generally will be larger and much better equipped and supplied than today's FAPs and SVAs.

- The prevailing practice of medicine will be substantially reoriented. The SVP will be staffed by physicians and nurses newly trained or retrained in the principles of general medical practice. Teams of general practitioners (GPs) and universal nurses (UNs) will be based at well-equipped, well-supplied SVPs and will deliver a much larger proportion of needed care than was previously delivered by rural primary care providers.

Under a Memorandum of Understanding (MOU) between USAID and the GOU, Abt Associates—through the USAID-funded ZdravReform Project—will provide technical assistance to the GOU at both the national level and in the Fergana oblast, where three rayons will be selected as demonstration sites. Specifically, Abt will assume responsibility for three major components of assistance. First, it will provide a health reform adviser to assist the GOU in developing laws and polices that support health care reform. Second, it will assist in developing training programs for primary care practices in the demonstration rayons, conducting a marketing campaign to educate the population about the benefits of the new system of primary care, and introducing new incentive-based payment systems for Rural Physician Posts. Third, it will develop a new computerized health information system.

Negotiations between the World Bank and the GOU for the $30 million loan for the World Bank Health One Project are scheduled for mid August 1998. The World Bank provided an advance payment of $750,000, which is allowing the GOU to procure equipment and technical assistance, in advance of the loan, for the project's three oblasts: Fergana, Syrdarya, and Navoi. USAID is providing computer equipment and training for the Fergana oblast; the British Know How Fund plans to provide training in the project area as of September 1998. As a complement to the Abt activities, the project will support the GOU health care reform program by providing support for strengthening the provision of primary health care services in rural areas. The project embodies three major components: strengthening the health care facilities at which rural residents receive primary health care services; developing, testing, and implementing reforms in the management and financing of rural

health care facilities to ensure that available services and resources are used in the most effective way; and strengthening the training of health care workers in general medicine. The project will help finance the costs of constructing or reconstructing approximately 158 SVPs, deliver technical assistance and training to health care providers, and purchase medical equipment, office equipment, vehicles, emergency drugs, and medical supplies.

C.2. USAID/CAR Programs

a. The Reproductive Health Services Expansion Program

The Reproductive Health Services Expansion (RHSEP) Program was developed in 1993 to improve the health of women and children in the five countries of Central Asia (Kazakhstan, Uzbekistan, Kyrgyz Republic, Turkmenistan, and Tajikistan) by reducing dependence on abortion as a means of fertility control. The RHSEP was implemented through six USAID Population Cooperating Agency projects: OPTIONS for Population Policy, SOMARC (Social Marketing for Change), AVSC (Association for Voluntary Safe Contraception), JHPIEGO (Johns Hopkins Program for International Education in Reproductive Health), JHU/PCS (Johns Hopkins University Population Communication Services), and MACRO Demographic and Health Surveys (DHS).

The RHSEP activities in Uzbekistan were initiated in January 1994 and included policy activities related to the improvement and expansion of reproductive health services, particularly in the private sector; clinical contraceptive training and service delivery; information, communication, and education (IEC) programs for family planning; marketing of contraceptives; and a demographic and health survey (DHS).

AVSC and JHPIEGO developed four model demonstration family planning (FP) service delivery centers in Tashkent, Samarkand, and Andjian. The clinics were equipped and stocked with contraceptives and continue to serve as regional training sites for training of trainers. From 1994 to 1997, AVSC and JHPIEGO conducted training programs in IUD insertion, Depo Provera administration, counseling, and infection control for more than 400 physicians. Eleven physicians received training in female sterilization procedures, and two were trained as trainers. Contraceptive technology update courses were provided for 450 health providers, including 350 pharmacists. USAID funding for AVSC and JHPIEGO ended in 1997. AVSC now works under a UNFPA agreement to continue providing technical assistance to the GOU in clinical contraception and service delivery.

The OPTIONS Project provided policy guidance in private sector development and assisted a group of physicians in organizing the Association of Private Physicians of Uzbekistan. Other OPTIONS assistance included tours to Turkey and the United States to observe private sector health service delivery and pharmaceutical production and sales. The visit to the United States also included consultations with the U.S. Food and Drug Administration on regulatory and legislative issues related to pharmaceuticals. In addition, OPTIONS sponsored a GOU official to represent Uzbekistan at the

1995 International Conference on Population Development in Cairo. OPTIONS concluded its activities in 1995 with the termination of its project.

In 1995, the SOMARC Project expanded the Red Apple Contraceptive Marketing Program from Kazakhstan to Uzbekistan. The effort is aimed at shifting delivery of oral contraceptives and injectables from the public sector to private sector pharmacies. Red Apple is now fully operating in the cities of Tashkent and Samarkand and in the two surrounding oblasts and is expanding into three additional oblasts: Fergana Valley, Namangan, and Bukhara. The GOU estimates that about 20 percent of all pharmaceuticals are sold through pharmacies. SOMARC also trains pharmacists and other health care providers in contraceptive technology both to increase their contraceptive knowledge and to provide them with the communication and counseling skills needed for working with clients. At the same time, promotion of Red Apple products provides contraceptive information through various media channels; IEC materials are produced to promote contraceptive use. A recent innovation is the development of Red Apple Rooms in mahallas (local communities) in Tashkent and Samarkand. The rooms offer information and counseling to women in their own neighborhoods in the Uzbek and Tajik languages as well as in Russian.

In 1995 and 1996, MACRO International conducted a demographic and health survey (DHS) of Uzbekistan. Published in early 1997, the DHS provides recent comprehensive baseline data on health and fertility in Uzbekistan.

b. Other USAID Programs

American International Health Alliance (AIHA) Partnership

AIHA sponsors a hospital partnership between the University of Illinois at Chicago Medical Center and the Second Tashkent State Medical Institute (TASHMI II). Assistance is targeted to neonatology and perinatal medicine, women's health, hospital and clinic administration, medical and nursing education, general surgery, and neurosurgery. Under a special Women's Health Initiative, Chicago assisted TASHMI II in developing a Women's Wellness Center. Areas of emphasis in the center include anemia, cervical dysplasia, and patient education. The center is located in a refurbished area of the institute and is equipped with the latest in diagnostic tools for use in training physicians. The center's personnel are particularly interested in developing in-school adolescent health education programs and have requested assistance with training materials.

Abt Associates

The Abt ZdravHealth Reform Project is providing technical assistance to the World Bank Health Reform Project in Uzbekistan. See above for further details.

C.3. Other U.S. Programs

Peace Corps

Currently, the Peace Corps provides English-language training and training in business administration. The in-country program expects a larger number of volunteers to arrive in May 1999, at which time it will become involved in primary health care services. Specific regions for Peace Corps health activities will not be identified until the new volunteers arrive. A consultant will arrive the end of February 1998 to prepare a proposal for health care activities.

Counterpart Consortium

The Counterpart Consortium assists developing indigenous NGOs by providing technical assistance in support of organization and administration and by identifying sources of financial support. In Uzbekistan in particular, Counterpart supports several women's organizations throughout the country that provide social, legal, and economic assistance, health care services, and advocacy.

Mercy Corps

Mercy Corps is a privately funded U.S. NGO that has been working in Uzbekistan since 1994. Funding for Mercy Corps has totaled $2.6 million in Uzbek currency derived from the sales of ghee (butter oil) in the Uzbek market in 1994. Mercy Corps works to further democracy and to establish a civil society in countries in transition. Activities include agribusiness, micro enterprise, and community health projects. In the course of Uzbekistan's transition, women have been losing rights and privileges as the society reverts to more traditional practices and beliefs. Mercy Corps is providing assistance to organizations/centers interested in counseling and assisting women in how to defend and retain their rights to education, employment, health care and family planning, and marital stability. Mercy Corps recently received a grant from USAID to translate and publish the reference book *Where There is No Doctor* for distribution to women's groups.

C.4. Other Donors

Donor coordination is weak; recently, however, UNDP took the initiative when it started conducting donor coordination meetings. USAID has agreed to be the coordinator for the subcommittee on health. With each donor working in different oblasts, there is a tendency not to coordinate and not to share experiences and information.

European Union—TACIS

The European Union will fund 17 projects in Uzbekistan at a total cost of $35 million. One of the projects will be in preventive health care at a total of $1.3 million over three years. Scheduled to begin in November 1998, the effort will provide technical assistance to the GOU in preparing a long-term action plan for developing a health care network and managing preventive care. Two long- term

advisers to be located in the Ministry of Health, Department of Science and Technology, will work in two pilot regions not yet identified. The funds will provide some equipment, but most will be allocated to technical assistance.

WHO

WHO works in two pilot areas in Andijan and Karakulpakstan and participates in the Central Asia Countries, Azerbaijan, and Kazakhstan Project (CARAK) for Improvement of Mother and Child Health and Family Planning on the District Level. Under the CARAK project, WHO delivers district seminars in maternal and child health and family planning and funds numerous other small projects related to safe motherhood, improved child care, and nutrition. WHO recently received a $100,000 grant to provide equipment for Ob-Gyn and child health services in Karkalpakistan. Funding in the amount of $60,000 was made available for CARAK activities in 1998. Dr. Roufat Yansapov, the WHO liaison officer for Uzbekistan, stated that WHO cooperates closely with the German Development Agency, Health Prom, UNICEF, and UNFPA in their various activities. UNFPA provides contraceptives and materials for the WHO training.

World Bank

The World Bank $30 million project is described above.

UNFPA/UNESCO

From 1992 to 1995 and again in 1997, UNFPA provided approximately $1.7 million for the procurement of contraceptives for the GOU program. European Union Credit procured contraceptives; in addition, the German Development Agency (GTZ) supplied approximately 900,000 IUDs in 1996.

UNFPA is participating in a joint IEC project with UNESCO. Funded for approximately $560,000, the project will support a limited but nationwide demonstration community outreach program to be carried out by the National Women's Committee. The effort will recruit and deploy women volunteers as community-based development (CBD) agents assigned to cover roughly all couples in the rural districts of selected provinces. The project will also build capacity in the Ministry of Education to undertake research, revise the curriculum, and develop text books for the existing course on reproductive health for adolescents and youth. In late 1997, the project conducted a KAP (knowledge, attitude, and practice) survey of 1,200 ninth-graders on contraceptives. The project will hold a series of four workshops for journalists and other media professionals and develop posters, flipcharts, pamphlets, billboards, and other materials for clinics and service delivery points.

UNFPA is also involved in an 18-month project. Under the project, which concludes in August 1998, AVSC has trained trainers in reproductive health. By project's end, a total of ten seminars will have been held, three for physicians and seven for nurses and midwives in the Tashkent, Surkhanda, and Kashkada regions.

IPPF

Supported by a UNFPA grant, IPPF is working with JHPIEGO to train trainers, improve infection prevention practices, provide training equipment and materials and technical assistance, and revise and adapt standardized curricular components for preservice and inservice medical and nursing/midwifery education.

GTZ

GTZ is working in the Tashkent and Namangana oblasts and is supplying some equipment and some contraceptives to 26 districts within the two oblasts; it has also supplied DPT vaccines nationwide. It is developing Uzbek-language brochures on contraceptives for distribution through feldshers. Nurses and midwives are receiving training in reproductive health with an emphasis on contraception.

II. SECTOR CONSTRAINTS

A. Access and Quality of Family Planning Services

A.1. Access

Because of the public health service's well-developed infrastructure, access to family planning services is not constrained by lack of service delivery points. Rather, constraints are associated with the efficient use of existing health resources and services and the need for health reform in all aspects of health care. In fact, the public sector provides virtually all family planning services (98 percent), although the source varies with the particular methods. For example, hospitals are the primary source for IUDs, injectables, and sterilization (although there are still very few sterilizations); government pharmacies and hospitals, women's consulting centers, and polyclinics are the primary source for contraceptive pills. In addition, the MOH apparently has ordered postabortion patients to receive family planning; that mandate should also increase access to contraception. The Red Apple social marketing program, although still in its infancy, is beginning to function as a source for pills (3 percent in the 1996 DHS) and condoms (1 percent). In any event, heavy reliance on hospitals for family planning services (especially as a source of IUDs and injectables) reflects the general nature of public health care in Uzbekistan as discussed in Section I.C.1. The hope is that the planned health care reform will help shift provision of family planning services—which are primarily preventive care—away from tertiary and secondary care settings (including hospitals) and toward primary care centers and the private sector.

In theory, family planning services are free through the public sector, although an informal payment is apparently expected for some services. Even with informal payments, cost does not seem to be a constraint to client access to services. If people are willing to pay for pills, injectables, and condoms through the Red Apple program, as they appear to be, then the potential exists to recover some of the costs of family planning services. As discussed later in Section III, the GOU's reform efforts must address the financing of health services, with the cost of and fees for contraception among the topics.

While the USAID strategy development team saw no official documentation on policies and procedures that limit contraceptive choice, various interviewees suggested that guidelines indicate who can provide certain methods and which clients should receive certain methods. For example, at present, only Ob-Gyns are permitted to be trained to insert IUDs. As health care reform proceeds, a change to allow nurses and midwives to be trained to insert IUDs would be desirable. Further, sterilization is apparently routine after a C-section but is not yet accessible to those who might favor it over an IUD for effective, long-term contraception. In addition, a woman must apparently obtain her husband's consent before sterilization.

Knowledge of sources of contraception is one of the indicators of access to family planning services. Indeed, knowledge of at least one source is extremely high among women in Uzbekistan; however, 84 percent of women using contraception know of *only one* source. Thus, most women do not, practically speaking, have an alternative to their current source, although the lack of an alternative is not a problem unless the quality of services is unsatisfactory, as is discussed later. The 1996 DHS shows the factors that are important to women when they have a choice in source of services. For example, 63 percent of the sample of women from Tashkent reported that they knew more than one source of contraception and that they chose their current source primarily for two reasons: convenient location or hours (42 percent) or competent, friendly staff (15 percent). Such factors suggest that "good" quality services will influence client choice.

A final component of access to services is the level of nonuse of contraception due to psychosocial factors or barriers. Of currently married women of reproductive age in Uzbekistan, 44 percent were not using contraception at the time of the 1996 DHS. Of the group, 41 percent did not intend to use contraception in the future. The reasons for their intended nonuse shed light on some of the psychosocial barriers to contraceptive use. For women under age 30, just over half were not using contraception because they wanted children. Another 36 percent did not intend to use contraception because they or their husband opposed contraception, they did not know of a method, or they had health concerns. Among women age 30 and over, nearly one-third had no need because they were postmenopausal, subfecund, or had undergone a hysterectomy. However, 51 percent of these women did not intend to use contraception because of their husband's or their own opposition to or health concerns regarding contraception. Thus, for a substantial proportion of nonusers of any age, access to family planning is limited by psychosocial factors. These same women might be potential users of contraception if they and their husbands were provided with adequate information on the benefits of family planning.

A.2. Quality

Range of Contraceptive Methods Available

The range of contraceptive methods available to women in Uzbekistan is expanding. While IUDs continued to be the predominant method as of 1996, the availability of other methods is increasing. UNFPA has provided oral contraceptives, injectables, and condoms. The Red Apple Program has supported the provision of two contraceptive injectables and five low-dose oral contraceptives through more than 550 commercial outlets across the country. Though still extremely limited, access to sterilization, including minilap, is improving as Ob-Gyns undergo training. As mentioned, breast-feeding (but not exclusive breast-feeding) is widely practiced but is not used as a method of lactational amenorrhea.

The team did not undertake an assessment of the availability of contraceptive supplies at the public health system's service delivery points (SDPs) around the country. However, the 1997 AVSC assessment found that contraceptives were in adequate supply at a large number of facilities visited in two oblasts while a deputy director of a maternity hospital in Samarkand stated that the hospital's supply of Depo Provera was low. (The MOH has apparently asked UNFPA for help with additional supplies of Depo Provera, but UNFPA has no more funding available for contraceptives in 1998–1999.) At larger medical facilities, other supplies such as vaginal specula, gloves, and antiseptic materials were in short supply; smaller facilities lacked basics such as gynecological tables. The UNFPA representative in Uzbekistan suggested a periodic assessment of the contraceptive commodity logistics system to see if products are reaching all SDPs.

Technical Competence

Training in reproductive health, contraception, IUD insertion and removal, sterilization (especially minilaparatomy), STDs, quality of care, counseling, and infection prevention is helping to improve the level of technical competence among health care providers. USAID and UNFPA have supported AVSC's training of trainers and others who will then have the necessary skills to continue training still other providers. Apparently, providers and clients have been noticeably receptive to training in counseling; in fact, follow-up with clients suggests a high level of satisfaction with the new emphasis on counseling. With training efforts still very much in the early stages, the GOU needs to emphasize continued training to ensure that an increasing number of health care providers will benefit. For example, many Ob-Gyns lack training in sterilization and therefore still do not accept that method as an appropriate type of contraception. On the other hand, some Ob-Gyns have developed the technical skills but lack the necessary equipment (interview with Sultanov) for performing the procedure. Further, a large number of female medical and nursing students are unaware of women's concerns in the area of reproductive health and rights. Under the Red Apple Program, SOMARC has supported training of health care providers (both Ob-Gyns and general practitioners) and pharmacists in contraceptive technology and counseling.

The team considered an MOH conference on sterilization in March 1998 an important step in according priority to both training in and the provision of sterilization within the public health system. Some observers, however, have voiced concern that as more Ob-Gyns undergo training in sterilization and make the procedure more widely available, providers may overlook client choice and unduly promote sterilization. For example, just as extragenital diseases are a medical indication for induced abortion (only healthy women should have babies), medical indications for sterilization (e.g., at least two or three C-sections) may encourage providers to dictate that women undergo the procedure.

With assistance from JHPEIGO and support from IPPF, the MOH is developing an appropriate training curriculum for the MOH training institutes. The ongoing effort should further ensure that health care providers receive necessary training through both preservice and refresher training programs. In addition, while JHPIEGO's service delivery guidelines in family planning have been translated into Russian, it is not clear how widely the guidelines are used in either training or service delivery.

A recent AVSC needs assessment funded by UNFPA pointed to a lack of information about the advantages and disadvantages of different contraceptive methods (including information on the duration of IUD use and the method's contraindications). The assessment also noted that provider attitudes and biases toward different methods limit client options (AVSC, 1997). Further, evidence suggests that physicians have been instructed to provide IUDs to as many women as possible despite the range of contraindications. Moreover, some physicians find the IUD preferable to oral contraceptives because of some women's failure to take their pills regularly. In addition, physicians feel that they do not have adequate time during the 15 to 20 minutes allotted per patient to provide complete information on contraception. The assessment also found problems with infection prevention among health workers and a lack of training information on infection prevention.

Under the GOU health reform program, general practitioners and nurses will assume increasing responsibility for service delivery. However, as long as provision of contraception remains largely the province of specialists, the role of GPs and nurses will continue to be limited. A decree apparently issued in 1997 allows trained GPs to insert IUDs, although it is not clear how many GPs provide the service. Further, while some specialists (former pediatricians and internists) have been trained to become GPs, they apparently do not yet feel sufficiently proficient to insert IUDs. In addition, nurses and midwives do not receive adequate training in counseling and infection prevention. In any event, given the inadequate ratio of physicians to midwives, there is a critical shortage of midwives at the primary health care level. These are important issues as health reform goes forward. GPs, nurses, and midwives play a crucial role in providing family planning in many other countries and, with appropriate training, could do so in Uzbekistan as well.

Information to Clients

Information for clients and the general public about reproductive health, particularly family planning and STDs, is widely considered vital to improving the quality of services. Yet, the consensus holds

that women for the most part are familiar only with IUDs and abortion. The DHS data largely support this consensus, although the situation is improving. The Red Apple Program has made some initial efforts in information dissemination by providing pamphlets, training peer counselors, conducting community-based meetings on contraception, and developing mass media advertising to increase the public's knowledge of a range of modern contraceptive methods. Here, again, the activities are just a beginning, and the limited scope and scale of information for clients and the general public is a continuing constraint.

While the range of methods available in Uzbekistan is expanding, general concern suggests that client choice of contraceptive methods may not yet be part of the mind set of either providers or clients. Given the legacy of the Soviet health system, choice was limited not only by the absence of methods but also by a highly medicalized, curative approach to care, a provider bias toward a method preferred by specialists (Ob-Gyns) and controlled by providers (i.e., the IUD), and the lack of client counseling. Even today, the health care sector continues to ignore the importance of client information and counseling, both of which can help ensure that client choice improves as the number of available methods of contraception expands. The AVSC assessment concluded that the lack of educational materials, especially in the Uzbek language for both clients and health care workers, presents a serious obstacle to the improvement of services.

Follow-Up and Supervision

The team found little information on or evidence of either client follow-up or supervision of client activities, suggesting that the MOH devotes insufficient attention to both areas. The 1997 AVSC assessment reported no follow-up of women who received an IUD after delivery.

A.3. Program Image

Fortunately for the future of family planning in Uzbekistan, general attitudes toward family planing are highly positive. The vast majority of women (91 percent) approve of family planning, although a smaller proportion (72 percent) of women report that their husbands approve. According to wives' perceptions of husbands attitudes, both partners approve of family planning in 70 percent of marriages. (The next survey to be carried out in Uzbekistan should include a sample of men to determine if the wife's perception is accurate.) Furthermore, a high percentage (78 percent) of currently married women who knew about a contraceptive method had discussed family planning with their spouse.

Interestingly, a sizable proportion of younger women had *not* discussed family planning with their spouse (48 percent of 15–19 year olds and 35 percent of 20–24 year olds), thus suggesting the need to direct more information to younger couples. The team heard that the GOU was providing premarital counseling on family planning as a condition of couples' obtaining a marriage license. Physicians from the maternity hospital in Samarkand deliver a lecture on family planning once a week at the local marriage bureau. However, it is unknown how widespread such sessions might be. On a related topic, it appears that husbands and mothers-in-law frequently decide on the number of

children a couple will have. Accordingly, the limited role of women in key reproductive decisions constrains women's assumption of more responsibility for their own reproductive health. Of course, males may be part of the constraint and should be part of any effort involving client information and public education.

The majority of women (77 percent) have favorable attitudes toward family planning messages broadcast on radio or television. Only 4 percent find such broadcasts unacceptable, and another 19 percent are unsure. Although the Red Apple Program is still new, DHS data show that 94 percent of respondents from Tashkent had seen the program's logo and that 72 percent knew what it signaled. In general, these favorable attitudes and findings bode well for future efforts to conduct public information and education campaigns on family planning, suggesting no major constraints to expanding such efforts or to achieving success.

B. Public Sector

The GOU does not appear to have established a framework for reproductive health policy. The GOU Ministry of Health generally sets policy through decrees, with each decree dealing with one issue or event that involves a major policy change or a simple announcement that the MOH is supporting a conference on a stated subject. For example, the GOU has issued decrees and orders on training GPs to insert IUDs, postabortion contraception, the establishment of the Healthy Nation Program, a national seminar on voluntary sterilization, etc. However, it is not clear that the needed legal or regulatory policies are in place for the unrestricted delivery of reproductive health services. In addition, it is not clear that existing policies and regulations are consistent with each other. All currently in-place policies and regulations need to be widely disseminated within the health system and then reinforced. The team believed that "folk" policies are still prevalent in Uzbekistan; that is, a clinic "gatekeeper" promotes his or her personal "folk" policy until it is believed to be true.

While health care personnel are aware of the various decrees, the development of a framework for reproductive health norms that includes the information from all of the decrees and other sources related to reproductive health could provide a useful reference and serve as a basis for developing guidelines for health care personnel. A framework is especially important as physicians and other health care personnel begin to assume different roles under health reform. An assessment needs to determine what policies and regulations currently exist, what gaps exist, and what additional regulations, if any, are needed.

C. Private Sector

C.1. Nongovernmental Organizations (NGOs)

Private nongovernmental organizations in Uzbekistan are in the early states of development and, as a result, are generally fragile. In addition, because some NGOs have strong government connections, they experience difficulty in differentiating between their role and the role and position of the government.

The Counterpart Consortium is working to support and strengthen NGOs to enable them to address women's legal, social, and health needs. One NGO has expressed an interest in developing an affiliation with the Planned Parenthood Federation of America (PPFA). Various NGOs have the potential to become advocates as well as sources of information and education for reproductive health; however, they still need assistance and support. In the near future, it is not realistic to expect any NGO in Uzbekistan to deliver reproductive health services.

C.2. Weak Private Sector

Only a few private clinics exist in Uzbekistan. By way of anecdote, the team heard of one clinic in Fergana and two in Tashkent. Despite limited experience in establishing private medical practices, clinic sponsors apparently encounter little difficulty in setting up private clinics as long as they have the necessary funds. It is difficult, however, to run the business profitably. When asked about the fees charged for services in one private clinic, one of the clinic's owners stated that the prices were usually about the same or higher than the "under-the-table" payments expected in the public clinics. Of course, the very poor would have to depend on public clinics.

If the GOU wants the private sector to deliver health care services, it needs to ensure that the necessary legal and regulatory policies are in place. The GOU did pass a decree in December 1997 promoting private medical practice; what remains unclear, however, is the impact of tax laws, import laws for equipment, and the convertibility issue (discussed below) on private practices. The GOU needs a clear policy and strategy for strengthening the provision of health care services through pharmacies and private practitioners.

In October 1996, the GOU dramatically cut the quotas for the conversion of som (the Uzbek currency) to foreign exchange. This action has had a major impact on the private/commercial sector, including the USAID social marketing project. For example, the Jurabek network of pharmacies, which carried Red Apple contraceptives, has closed 17 out of its 19 pharmacies. Sales of Red Apple contraceptives have dropped because of the lack of product. At the Joint Committee meeting in Washington in early March 1998, however, the GOU promised to resolve the convertibility issue, at least for Red Apple contraceptives. In any event, the matter of convertibility needs to be monitored, and all contraceptives—not just Red Apple contraceptives—should be exempted from the convertibility quota.

D. Management Constraints

The Office of Social Transition (OST), USAID/CAR, is a small regional office whose limited staff is responsible for a large and complex portfolio that covers five countries. The office in USAID/Tashkent is likewise small and stretched to provide oversight for all the projects and programs in Uzbekistan. In addition, the office lacks the technical staff for adequately backstopping reproductive health projects; therefore, Almaty is responsible for most project and program monitoring.

III. SECTOR STRATEGY

A. Public Sector Reform

The government has embarked on a major health reform program aimed at improving rural primary health care. Under an MOU between USAID and the GOU, Abt Associates—through the USAID-funded ZdravReform project—will provide technical assistance to the GOU and to the Fergana oblast, where three rayons will be selected as demonstration pilots. In addition, assuming successful negotiations between the World Bank and the GOU in the spring of 1998, World Bank loan funds will support health care reform in three oblasts (Fergana, Syrdarya, and Navoi). The technical assistance to be provided by Abt Associates is considered an important part of the implementation plan for the MOU between USAID and the GOU and for the World Bank project.

Abt's regional director recognizes the need for USAID to play a role in strengthening the delivery of reproductive health services in the context of health care reform. The team proposes an early October 1998 assessment of the reproductive health services available in the World Bank rayons to identify areas for USAID intervention. (See Annex A for a draft scope of work for this assessment.) Potential areas for USAID assistance identified by the team are training, IEC, and advocacy. These potential areas are described in more detail below.

Technical competence of service providers. Both preservice and in-service training in reproductive health (especially for general practitioners, nurses, and feldshers, all of whom are expected to play an enhanced role under health reform) are an essential component in improving the quality of reproductive health services. Training materials have been translated into Russian, and service delivery guidelines for reproductive health and family planning have been revised and approved by the GOU. In addition, AVSC has developed a counseling training curriculum in RH as well as training materials on counseling. Given that materials for training in most areas of RH already seem to exist, implementation of training for service providers could begin shortly.

Information for clients. Clients need information on most aspects of reproductive health. To that end, the team recommends that Abt work closely with SOMARC to develop client information materials (see below for more discussion on IEC materials). Materials could be distributed in the pilot areas through rural health centers, local NGOs, and the local community councils being established by Abt. In addition, Abt and SOMARC should collaborate to train peer counselors in how to encourage community councils and communities to hold education and information sessions.

Advocacy for reproductive health. Communities participating in focus groups conducted by Abt Associates identified the need to strengthen reproductive health as one of several important issues that should be addressed. Abt should ensure that community councils receive the appropriate training to become strong advocates for health reform and reproductive health.

Improving maternal care. Abt should ensure that the health reform project devotes appropriate attention to improving maternal care, particularly as related to the lack of prenatal iron

supplementation to treat anemia, excessive use of C-sections, the high rate of infections from C-sections, and limited capacity for blood transfusions for hemorrhage.

Recommendation No. 1. USAID should conduct an assessment in early October 1998 to identify the areas for USAID interventions in reproductive health in the World Bank/Abt pilot project. Based on the assessment, USAID should provide field support to the Global Bureau for the Partnerships for Health Reform project for Abt's provision of technical assistance in implementing the activities suggested by the assessment team.

B. Policy/Dialogue/Assistance

The team recommends that USAID/CAR provide policy support to the GOU as well as assist in the health care reform program. To support both health care and private sector reform, the GOU is making and changing laws, regulations, and policies that have a direct impact on reproductive health. In view of the rapidly changing environment, it is essential that USAID provide the appropriate government officials and influentials with the information and assistance they need to understand the impact and long-term consequences of the polices they are adopting. Government officials also need to recognize the role and importance of the private sector in the delivery of health care services and to understand the impact of health care reform policy on the financing and delivery of health care services in the commercial/private sector.

To assist the GOU in the policy area, the team recommends that the policy adviser assigned to Turkmenistan spend one-third of her or his time in Uzbekistan to assist in addressing the specific policy issues set out below and any others that may be identified by the policy adviser and USAID. The policy adviser would also assist USAID/Tashkent in crafting policy agendas and talking points developed from the policy issues for discussion with the GOU at all levels, i.e., the U.S. Ambassador, the USAID representative in Tashkent, and, if appropriate, the USAID/CAR regional office. The following is a set of key issues for policy dialogue with the GOU:

<u>Establishment of the legal and regulatory framework needed to support reproductive health.</u> The policy adviser should assist the GOU in establishing a framework for reproductive health. That framework should be based on an assessment of existing policies, policy gaps, contradictions among policies, and policies or issues that obstruct the provision of reproductive health services.

Under the ZdravReform Program, Abt Associates will maintain a dialogue with the GOU at the national and local levels to ensure that legal policies supporting health reform exist and/or are developed. If requested, the program will assist the GOU in preparing new or revised legislation related to the framework for health care reform. In particular, the policy adviser on reproductive health will work closely with the ZdravReform Program to ensure that reproductive health issues are considered in the development of new legislation or policies. The adviser will also provide information to Abt regarding the gaps in reproductive health policies that must be addressed by general policies.

Rationalization of public and private sector roles in service provision. The GOU needs to carry out the necessary legal and regulatory changes that will allow the development of private sector service delivery—whether through private clinics or private pharmacies. One important element for the long-term sustainability of health service delivery is a strategy to segment the health market, thereby permitting the GOU to concentrate on the poorest population. A newly developed private sector could provide services to those who can afford to pay, thus eventually lightening the public sector's service delivery burden.

Contraceptive commodity supply. The supply of contraceptives to the public sector is currently not a problem as donors provide all contraceptive commodities. The future supply of contraceptives, however, is not certain and therefore should be monitored to prevent any problems. With contraceptive commodities not listed on the "essential drug" list included in the World Bank project documentation, monitoring becomes especially important.

Recommendation No. 2. USAID/CAR should provide field support to the Global Bureau for the POLICY Project to fund a policy adviser for both Turkmenistan and Uzbekistan. The adviser should be stationed in Turkmenistan and spend one-third of her or his time in Uzbekistan.

C. Private Sector

The role of the private/NGO sector in family planning is relatively new but is particularly promising. Further work is recommended to build on and strengthen the current efforts of the Red Apple contraceptive social marketing program and to explore an expanded role for NGOs. Moreover, in view of the glaring need to disseminate to the general population accurate and up-to-date information on the health and social benefits of family planning and modern contraception, the private sector is well positioned to carry out public education activities that draw on the early work of the Red Apple Program. Such activities are an important strategy for conveying to couples that the selection of a contraceptive method should be theirs after consultation with providers—whether medical professionals or pharmacists. The following describes the proposed reproductive health strategy in the private sector:

C.1. Contraceptive Social Marketing

The Red Apple Program, which started under the USAID-funded SOMARC project, has proven highly successful in Uzbekistan. If the current problems with currency conversion can be resolved, the team recommends that USAID continue to support the Red Apple Program so that the program can extend its reach beyond Tashkent and Samarkand. The currency convertibility issue was discussed at the Joint Committee meeting in Washington in early March 1998. At that time, the GOU promised to solve the conversion issue regarding Red Apple contraceptives. Some progress has been made in providing currency conversion for contraceptives, but recent responses represent only a temporary measure such that USAID/Tashkent needs to continue monitoring the conversion situation. Among the activities recommended for support by the contraceptive social marketing project are:

- continued support for and expansion of advertising (including point-of-purchase advertising) and public information activities through the mass media (radio, television, newspaper, and posters) to increase awareness of various modern contraceptive methods (especially orals, injectables, and condoms). Awareness of such methods is improving, but additional efforts are needed to counteract misconceptions and fears about various methods;

- continued training and education of pharmacists in family planning and contraception to help them in their role as providers of information and contraception to consumers. Some of the training should be directed to strengthening the business skills and practices of pharmacists, for whom private enterprise in Uzbekistan is an entirely new notion;

- continued work with the nascent pharmacists' association to strengthen its role in the legislative process as regards pharmacy practices in Uzbekistan. The Physicians' Association of Uzbekistan counts about 4,000 members, including pharmacists and physicians. The association may function as an alternative NGO with which the SOMARC project could collaborate if the pharmacists' association proves not to be a viable NGO. Among the specific activities that might be undertaken by either the Physicians' Association of Uzbekistan or the Association of Pharmacists are study tours to other countries to learn about the role of pharmacists' associations, support for a partnership with a U.S. pharmacists' association to be identified, and training of pharmacists in the business practices that USAID supported in other countries such as Romania;

- continued support for and expanded training of peer counselors as well as delivery of related education and information sessions to potential clients. Some "consumer education" sessions have been conducted in mahallas (local community units). SOMARC's peer counselors might cosponsor community-based education activities with NGOs. The team recommends that such activities be carried out in the three oblasts targeted for health reform by the MOH and the World Bank project and that SOMARC work with the Abt staff on these activities;

- private and public sector dissemination of accurate information about the health and social benefits of family planning and modern contraception. It is especially important that consumer-oriented pamphlets on modern contraceptive methods emphasize client choice. Collaborating with Abt and NGOs, SOMARC should develop materials that are appropriate for both clients and service providers. The client materials could be distributed through NGOs, the community-based councils being organized by Abt, associations (such as the private Physicians' Association of Uzbekistan), and private clinics. With men apparently overlooked in recent education and information activities, consideration should be given to preparing a pamphlet on the role of men in decisions about family planning and contraception.

  Other possibilities for community-based activities include the development of pamphlets and posters on RH topics for distribution to the general population, education sessions for youth clubs (if they exist, or community centers), support for a counseling and information hot line, and development of a local resource center;

- developing links with ongoing activities in the education sector and with schools currently supported by UNESCO. The Red Apple Program has made some initial forays into providing information to schools and students;

- encouraging the Red Apple Program to place advertisements in the new journal for general practitioners (started by Dr. Zarkirov of the Medical Institute in Samarkand), thereby helping to inform GPs about contraceptive methods. By paying for regular advertisements, the program would also help support the journal (to date, only 1,000 copies of the journal are being printed). Given that the role of GPs in health reform will increase significantly in the years to come, the journal may prove to be an effective way to keep GPs aware of contraception; and

- limited support for work through the Red Apple Program with journalists and coordinated with the Democracy Project and perhaps the BBC's program with journalists, now being developed in Uzbekistan.

Recommendation No. 3. USAID should provide field support to the Global Bureau for the follow-on SOMARC project to support contraceptive social marketing efforts in Uzbekistan for the next two to three years.

C.2. Nongovernmental Organizations (NGOs)

Meetings with women NGO leaders revealed an interest in learning more about the Planned Parenthood Federation of America (PPFA). One woman had visited a PPFA affiliate and wanted to know more about how an affiliate works. A partnership between a women's NGO and a PPFA affiliate would allow that NGO to function as an advocate for reproductive health while disseminating information on women's reproductive rights and specific contraceptive methods. It is not recommended that the NGO actually deliver services at this time.

Recommendation No. 4. USAID/CAR should support the new Health Partnerships project to promote a partnership between a women's NGO and a U.S.-based Planned Parenthood Federation of America affiliate.

Annex A

UZBEKISTAN REPRODUCTIVE HEALTH ASSESSMENT

I. BACKGROUND

With the assistance of the World Bank, the Government of Uzbekistan (GOU) is embarking on a major health reform program to improve primary health care in three oblasts (Fergana, Syrdarya, and Navoi). A project loan is expected to be negotiated with the World Bank in spring 1998, with work initiated in the summer 1998. Under a Memorandum of Understanding (MOU) between USAID and the GOU, USAID has agreed to provide technical assistance under the Abt ZdravReform project in the three demonstration rayons in the Fergana oblast.

The Abt technical assistance effort will initially focus on rationalizing the primary health care system, particularly through the SVPs (primary health care centers) and the FVPs (feldsher accoucher posts). Rationalization calls for more effective administrative and financial management, cost recovery, pharmaceutical management, and reduction in excess bed capacity and the number of physicians. Initial efforts will also focus on upgrading and equipping facilities. The level of emphasis to be placed on service delivery remains unclear, although Abt has prepared a comprehensive list of services to be delivered.

Training for physicians and nurse midwives is an integral part of the program. Expatriate trainers will use WHO protocols such as Integrated Sick Child Management and the Learning Materials on Nursing (LEMON) program in their training efforts. Other activities in Uzbekistan that are expected to serve as resources for the training programs include the GTZ training in family planning, the Health Prom Safe Motherhood program, the British Know How Fund's curriculum development for physicians, and the BBC IEC training program for improving the communication skills of physicians. The project will also work closely with community (mahalla) councils to enlist community participation and support in health care reform.

In February 1998, a team from USAID/CAR and the United States conducted an assessment of reproductive health services in Uzbekistan. That assessment represented a first step in developing a reproductive health strategy for the next three to four years. The team met with the World Bank and Abt to discuss a potential role for USAID reproductive health services in the Fergana oblast. Home to approximately one-third of Uzbekistan's total population, Fergana—located in a rural area and characterized by a high birth rate—seemed an appropriate jurisdiction for interventions. Moreover, the model reproductive health training center established in 1994 by AVSC in Andijan, which is adjacent to Fergana, could serve as a center for additional activities.

The Abt regional director acknowledged that USAID needs to play a role in the reform project to help strengthen the delivery of reproductive health services. Owing to time constraints, the USAID strategy team was unable to visit Fergana and therefore could not define the most appropriate assistance or potential strategy. It would, however, be beneficial to explore ways to strengthen the

delivery of reproductive health (RH) services under the reform package once the SVPs are reequipped and the roles of the personnel redefined.

Scope of Work

A team of reproductive health specialists, including the Population Officer in Almaty, the ENI Bureau Women's Reproductive Health Specialist, an AVSC representative, a specialist from the Mothercare project, and the policy adviser (if she or he has been selected), will travel to Uzbekistan on or about October 1, 1998.

The team will visit Fergana to assess the reproductive activities in the three World Bank Health Reform Project rayons. The assessment will include the following:

1. Meetings with USAID, World Bank, Abt, and MOH personnel to discuss the current status of RH services in the WB rayons in Fergana oblast

2. An overview of RH services in the WB rayons to include

    a. sites for the delivery of RH services

    b. numbers and categories of personnel to be trained in RH

    c. RH training programs under the WB project

    d. client access to services

    e. quality of services (as measured by range of method; technical competence of service providers; information available for clients; client-provider interaction, especially counseling; follow-up and supervision)

3. Identification of

    a. areas for USAID interventions in RH, including training, IEC, and advocacy for improved and expanded RH services

    b. counterpart organizations

    c. possible areas for improving maternal care

4. Specific recommendations for USAID interventions in RH activities

Annex B

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Annex C

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